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Coercing for Public Health: Reflections on the role of coercion in public health emergencies

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Abstract
The workshop, *Coercing for Health: Transdisciplinary Approaches to the Ethics of Coercive Public Health Policies* was held at the University of Oxford on July 3rd and 4th, 2024. This paper provides both a summary of the workshop proceedings, and reflections and directions for future research in coercive public health measures. The workshop consisted of four key parts: defining coercion; history and legal analysis of coercion; public health ethics perspectives on coercion; experiences of public health coercion. According to our reflections, some key questions

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remaining for further research include: what is the difference between coercion and enforcement? Who gets to define and address coercion? How do structural factors affect health and experiences of coercion? We encourage others to continue to work on this important area, to ensure the ethically acceptable and well-understood implementation of any future coercive measures in the sphere of public health.

Introduction

Many responses to the COVID-19 pandemic saw the widespread use of seemingly coercive public health interventions—such as travel restrictions, mask mandates and stay-at-home orders—that limited some individual rights (Marciano and Ramello 2022; Peralta-Santos et al. 2021). Despite the use of these measures for the protection and promotion of public health, their ethical acceptability and public justifiability remain contested and subject to debate (Smith 2024). Yet, we usually hold certain kinds of routine coercion to be acceptable. In that case, which coercive measures used in public health emergencies are acceptable, and which are not? Why, and how can we tell the difference between the two? Though coercion is a long-standing part of the public health armamentarium, there remains a need to properly answer these questions, considering and conceptualising the circumstances under which the use of coercion is justified, with the overall aim of determining the appropriate role for coercive measures in future responses to public health threats. To this end, on the 3rd and 4th of July, 2024, scholars from diverse disciplines were hosted by the University of Oxford's Ethox Centre for an international, interdisciplinary workshop on coercive public health measures (Johnson et al. 2024a). The workshop, *Coercing for Health: Transdisciplinary Approaches to the Ethics of Coercive Public Health Policies* explored many questions relevant to this special issue of *Monash Bioethics Review*.

With COVID-19 and other emerging health challenges continuing to shape global policy, the workshop aimed to examine the ethical implications of coercive measures taken during public health crises. The aim was to shift this long-standing debate about the use of coercive measures in public health out of disciplinary silos. Different disciplines have understood coercion in various, sometimes incongruent ways (Finogentova et al. 2022), and this interdisciplinary workshop was an opportunity to find common ground in a conceptual and ethical approach to coercive public health measures. The disciplines represented included philosophy, sociology, anthropology, law, social policy, epidemiology, clinical medicine, public

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health ethics, and history. In this paper, we first briefly summarise the proceedings of that workshop. Though our workshop had lofty aims for developing an applied approach to coercive public health interventions, it was challenging to reach any kind of consensus, highlighting the contentious and fraught nature of this area. Consequently, we do not proffer an agreed approach to coercive public health measures. Instead, after summarising the workshop proceedings, we offer reflections on three key areas of discussion highlighted as important directions for future scholarship: i) enforcement *vs* coercion-on-paper as ethically important; ii) who gets to define coercion; and iii) structural factors influencing health and effects of coercive measures.

A summary of workshop proceedings

The workshop comprised four broad thematic debates: defining coercion (as a philosophical and normative concept); experiences of coercion in historical and contemporary public health responses; coercion in public health ethics; and contemporary, policy experiences of coercion in public health.

Defining coercion

The workshop began with presentations from Max Kiener, Adia Benton and Justin Bernstein on "Defining Coercion". In the opening session, speakers examined conceptions of coercion across philosophy and anthropology. A first point of difference was between, on the one hand, the traditional philosophical approach of stipulative definition followed by classification of practical examples as coercive or not depending on whether they have the required features of a coercive action, and on the other hand the anthropological approach of more descriptive conceptualisation from a combination of experience, intuition, and network-definition. While the former approach provides a clearer definition useful for setting boundaries to discussion, it does not necessarily reflect real-world contexts and subjective accounts of coercion. The latter approach leaves a broader space open for the inclusion of perceived coercive actions in discussion, but at the cost of hazier edges to the concept. One means of resolving this difference is to adopt a pragmatic, 'moral explanation' approach for including or excluding actions from receiving the 'coercive' label, employing intuitive examples of coercion and then

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identifying features that make them be perceived as coercive, to then build a characterisation of coercive measures.

The contested nature of coercion became clear as even our initial discussion saw debate on how to (and whether we even should) define coercion. Drawing on Kiener's presentation, we used Nozick's account of coercion as a point of departure, and focussed on five components: types of coercion, the means of coercion, the moralisation of coercion, whether there is a success criterion for an act to be coercive and whether context influences whether an act is coercive (Kiener 2020). Contemporary debates frame coercion in relation to interpersonal experiences and cases, narrowing what constitutes coercive conduct to instances of threats (as opposed to offers). Simultaneously, the use of the term outside these circles has broadened considerably, referring to a broad array of social pressures, the structure of society or even softer actions such as 'nudges' (Cottam 2005; Quigley 2014; Rothstein 2002). Within the bioethics and public health community, debates focus more on whether such coercion is justified in relation to its aim, purpose and effectiveness in promoting public health and whether governments may use coercive measures to protect and promote population health (Cottam 2005). This disjuncture may make using a traditional definition of coercion impractical, as it may not be applicable to the spectrum of public health policies that need to be assessed.

This raises a fundamental question (explored in detail in our reflections in the next section): where the concept has such diverging meanings across disciplines, who gets to define what coercion is and whether it requires justification? Practically speaking, this has implications for those at the coalface of decision-making, but also for the public who experience the effects and consequences of these decisions.

Coercion: history and law

The debates from the first session dovetailed with the next session on "Coercion in Historical and Contemporary Public Health Response", where presentations from Alexandre White, Hohee Cho and Petronell Kruger outlined case studies on the use of coercion over time from legal and historical perspectives. Alexandre White assessed the coercive nature of the historical International Sanitary and International Health Regulations, which primarily were concerned with minimising disruption to trade rather than public health aims (White 2023). These regulations were built on imperial and colonial power, and assumptions about the paternalistic responsibilities and remit of these powers to promote sanitation, health, and hygiene among the

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populations they were oppressing (White 2023). Often, motivations were mixed, and the threat of 'tropical' and 'New World' diseases may have been an impetus for efforts to control epidemics (White 2023). It is perhaps unsurprising that the public health measures implemented under these instruments have been accompanied by instances of discrimination, xenophobia and other harms, and that many measures served little to no public health purpose.

Hohee Cho raised another historical example, involving the forcible quarantining of Hansen's disease patients in the Pacific islands (Cho 2022). Her presentation noted an apparent dissociation between coercion through use of force and there necessarily being negative consequences for individuals. In this example, inmates/patients of quarantine islands often experienced better living conditions than they might have had access to if not forcibly confined to the island.

Finally for this session, Petronell Kruger discussed complications with the implementation of coercive policies or strategies through law. With the example of HIV testing and treatment regimens in South Africa, she discussed how panic, late implementation of measures, and lack of political will can undermine the intended coercive effects of threats made through legislation (Kruger and Abdool Karim 2022).

In the discussion following this session, we used a framework to group areas of conversation in small-group work into the following categories: moralisation of coercion, synchronicity, context & time, power, subjectivity, structural factors affecting distribution of the burdens of coercion. These groupings highlighted a set of key connections: who defines coercion and whether it is considered subjective or objective is dependent on context and time, and also on material interests and power relations.

Coercion in public health ethics

The real-world application of coercive public health measures creates a need for an operationalisation of coercion that responds to the context of public health responses, and allows for their ethical evaluation. In our third session of the workshop, on "Coercion in Public Health Ethics", Maxwell Smith, Diego Silva and Rachel Gur-Arie grappled with how the development of coercive actions needs to respond to the specific content and context of population-level interventions. This session explored existing ethical assessments of contemporary coercive public health measures. Maxwell Smith initiated the session with

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discussion of how public health complicates coercion as, in this context, coercion does not always leave subjects worse off and attempting to avoid coercion can be self-defeating in that failing to implement slightly coercive measures in a timely manner may necessitate more coercive measures later (Smith 2024). Rachel Gur-Arie noted an equity-related concern with the enforcement of coercive measures, and specifically whether the burdens of enforcement were fairly distributed or overly burdensome on some individuals. Diego Silva capped the session with a discussion of how place shapes how we think about coercion, both building on some of his previous work (Pahlman et al. 2024) in referring to Australia's traveller quarantine measures during the COVID-19 pandemic, and exploring violations of the meaning of place more broadly in new work (Silva 2025).

The discussion succeeding this session explored the conflict between effectiveness and coerciveness which may be present in some public health interventions. Questions were posed as to whether we should be as concerned with coercion in the public health sphere, assuming it is in the effective pursuit of appropriate goals of public health. One problem with this approach is that effectiveness may slide into a quasi-absolute justification for coercive public health measures. This can lead to failures to evaluate less restrictive alternatives, and may even lead to the distortion of evidence, given political motives behind certain public health policies and pressures to look past uncertainty to convey a simple public health message that justifies a coercive measure. The appropriate weighing of values for and against a particular public health measure is an essential area for further work, perhaps irrespective of whether such measures are or are not called 'coercive'. Whilst such values are articulated in the recent literature, the appropriate weightings assigned to them have not been adequately discussed.

Experiences of coercive public health

The workshop concluded with presentations on "Experiences of Coercion in Public Health" from Deborah Nyirenda, Liana Woskie and Katherine Littler. In her talk, Deborah Nyirenda outlined four case studies of seemingly coercive public health measures, including mandatory vaccination, improving utilisation of health facilities for childbirth, measures to adapt to climate change, and 'voluntary' medical circumcision (Nyirenda et al. 2020). Each case study highlighted ethically important possible features of coercion, including arbitrariness of state action, marginalisation through indirect coercion, intersections with socioeconomic vulnerability and inequity. Liana Woskie continued the session with a detailed econometric study of

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incentivised sterilisation, during which she showed data suggesting that what often appear to be voluntary sterilisations in state-sponsored family planning campaigns may occur in under-age, under-informed, or over-incentivised women. In turn, these women would be characterised as having been coerced if using recognised UN definitions of coercion in sterilization care (Woskie 2025). Finally, Katherine Littler discussed how we might make coercive measures fairer in the distribution of their effects, through considering aspects of geography, race, political space, and other factors that might affect how coercive measures are experienced. There was a further discussion following this to consolidate thoughts and reflections on the workshop. We draw on some of the points raised during that final discussion in our reflections below.

Reflections and directions for future scholarship

By the end of the two-day event, it was clear that the ethical challenges of coercion in response to public health emergencies, including the mere act of identifying instances of coercion, demands further scholarly attention. Even within a highly willing, open group of academics, it was difficult to find common ground, particularly across disciplinary boundaries for discussing what a coercive public health measure is and whether it ought to be implemented. This highlights the need for continuing interdisciplinary engagement on this issue.

Historically, who is considered an ‘authority’ and what it means to legitimately exercise ‘authoritative power’ through coercion has been quite different from what we see today. The implementation of coercive measures is no longer only the remit of states; both the pressures of international norms and guidance, and the expanding power of large corporations have led to changes on who engages in coercion. Changing public attitudes toward coercive measures may require new explorations of what ethically acceptable coercive measures for the pursuit of public health might look like, and who should have licence to implement them (Ranieri et al. 2023; Smith 2024). At the same time as coercive authorities are changing, the structures that shape its effects are also changing. Social, economic, geo-political and cultural contexts all impact how the burdens of a coercive action (or the lack of implementation of an effective coercive action) are experienced (Johnson et al. 2024b). This contrasts particularly with directly interpersonal conceptualisations of coercion (e.g., in contracts) (Sager 2009). Where those subject to a coercive measure experience it in different ways depending on structural factors, this complicates discussions surrounding a broad-brush measure’s fairness, as well as discussions

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of the trade-offs between different kinds of rights and freedoms that might be incurred by a coercive measure (Giubilini 2023; Graham et al. 2023). This is thrown into relief when considering the differences in what a population-wide mask mandate, for example, means for people in Global North *versus* Global South countries, including considerations of access to high-quality masks, the burden of penalties for non-adherence, and supports provided, such as generalised and disability-focused communication supports (Aloui-Zarrouk et al. 2020 [preprint]).

Following the workshop, we distilled our reflections into three themes for future research on coercive public health measures.

Does defining coercion on paper even matter, or should we focus on experiences of enforcing public health measures?

The first question we are confronted with, in the wake of our discussions, is the value of defining what coercion is, or whether we should focus instead on the phenomenon at the source of moral contestation: *enforcement* of a public health measure. Even if an appropriate definition of coercion was identified for our context, it may be inapplicable to many portions of public health response that are inadequately enforced for the 'coerced' population to actually experience any burden or restriction. Should we care, then, about defining coercion, or merely focus on enforcement? On the one hand, without a clear definition, coercion becomes a malleable concept, open to wide interpretation and potential misuse by governments claiming to be 'anti-coercion' to gain political traction, perhaps even while engaging in what could be thought of as coercive practices without accountability. A wide definition could also be used to object to certain practices that aren't coercive, or that are instances of justified coercion. On the other hand, if we focus merely on the *enforcement* of public health measures, then there may be scope for the creep of restrictions in written documentation but without initial enforcement, and then later hard enforcement of these measures. Abuse of state power is more likely to arise through enforcement of coercive measures rather than just their adoption on paper, but adopting measures on paper is a first step that must be scrutinised in and of itself. For example, a coercive stay-at-home order might be permissible but the use of excessive force by the military in enforcing the stay home order would be impermissible; that the order itself is coercive is not dispositive of whether it (and the mechanisms of enforcement) is permissible. On the other hand, a measure that doesn't seem 'forceful' or 'enforced' at all, such as the example of

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incentivised sterilisation brought up by Woskie during the workshop, may be coercive in a way that is not encompassed by the idea of force or enforcement, especially where it undermines autonomy or voluntariness of compliance with a 'public health measure' like sterilisation in a more insidious way.

During our reflections, there was perceived value in sidestepping the question of whether a measure is or is not coercive, and instead focus on appraising the appropriateness of different forms of enforcement in public health (e.g., requirements accompanied by fines vs. being fired vs. being excluded from an activity). In this way, the ethical appraisal of public health measures turns not on whether those measures meet one or another definition of 'coercion', but rather on whether their method of enforcement is ethically justifiable. Yet, getting greater clarity on what does and does not count as coercive in public health was also perceived as valuable, both because ascribing a term to a set of activities can serve as a useful shorthand for ethical appraisal and because 'coercion' and 'coercive' continue to be commonly used as evaluative terms by the public and other stakeholders in public health.

There is also value in the concept of coercion that extends beyond this to recognising other, non-governmental actors, whose capacity for enforcement of a policy or regulation may be limited, but who may nonetheless aim to implement coercive policies (wrongly or rightly) (Rudden 2022). In this regard, we specifically consider large, multinational corporations, who may exert significant power and influence over people and governments alike (Gilmore et al. 2023). Whilst their enforcement of coercive measures they design can be challenged in courts of law, the core question is whether they had the right to create (or implement) coercive policies to begin with. Courts also become an imperfect tool to test coercive policies as, in many instances, the ability to use them to challenge coercive policies is limited to those who can access the judicial system, and often the Courts are a slow means to address impermissible coercion, particularly given the rapid nature of emergency responses (Gostin 2000; Abdool Karim and Kruger 2021).

We maintain, however, that enforcement, whilst not the core of coercion, remains important, particularly in the context of over-harsh enforcement or selective enforcement. Coercive measures, particularly in public health, often derive their significance for affected individuals not from their articulation in policy but from their implementation. A state equipped with robust enforcement capabilities can impose substantial burdens on its population, and thus *exercise* its

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coercive power against its citizens. Conversely, a state with weak or non-existent enforcement mechanisms may be unable to impose penalties, use force, or effectively provide threats that in fact coerce its population, even if its policies on paper appear to be coercive by virtue of threatening penalties or use of force.

Ultimately, the interplay between coercion and enforcement underscores the complexity of ethical analyses, and thus the need for responsive and rigorous tools to assist in such analysis. While the moral significance of coercive actions for individuals often emerges through its enforcement, a focus solely on enforcement risks lessening government accountability for more less well-enforced cases of what is still a coercive policy requiring independent ethical justification. Consequently, a comprehensive and robust approach to coercive public health must address both dimensions, offering a definition for coercion while also recognising the need to consider the relationship coercion has with enforcement. Recognising the need to define coercion, the next question then becomes, whose perspectives matter in formulating such a definition?

Who gets to define what coercion is and whether we need to justify it, reduce it, or eliminate it?

In considering coercive action from different disciplinary perspectives, it is apparent that what is seen as coercive often depends on the context in which it takes place and the situation of the people subject to it. That is, when considering public health interventions, perceptions of what is coercive are subjective—not only to those who experience the coercive actions, but also when the actions are considered in retrospect by different evaluators. This subjectivity invites critical inquiry: should we rely on externalist assessments, or should we privilege individual accounts of feeling coerced?

It is apparent that experience of coercion is deeply intertwined with power, something noted particularly by our colleagues in sociology and anthropology. In this respect, individual experiences of coercion may be essential for evaluation of coercive actions if we consider the experienced burdens of a measure to be relevant to ethical evaluation, particularly where marginalised or vulnerable populations are involved (White, 2024). Yet, we should avoid relying *solely* on an individual's feeling of being coerced when considering whether a coercive action is justified. There is some risk that subjective understandings of coercion may merely reflect the burdens individuals associate with measures rather than being generalisable or informative in a way that should guide policy. For instance, a coercive measure might appear more reasonable

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to those who have experienced the harm it seeks to prevent. There is also a potential for individuals to perceive themselves as coerced when others hold that they are not, or to fail to recognise coercion when we might think they are being coerced, such as in instances of coercive exploitation.

By contrast, we must also avoid relying solely on what might be termed ‘externalist’ or ‘objective’ accounts of coercion that rely on the stipulation of necessary and sufficient conditions to externally and uniformly evaluate an action as coercive or not, without reference to subjective experiences of ‘being coerced’. A wholly objective or externalist assessment of coercion may miss individual experiences of coercion that offer ethically relevant information for informing evaluation of a measure in a public health context. A useful direction for future scholarship could be exploring collective subjective accounts of coercion, and various ways of integrating individual perspectives into assessments of coercion that aim to evaluate policy. Also of interest would be the implications of proceeding with a 'consensus' definition that does not accord with how the public understands the term and experiences it, or proceeding with how the public tends to understand the term even if it is conceptually incoherent or ethically problematic.

Here we highlight Cho’s example of the communities with Hansen’s disease on remote islands, which simultaneously offered better living conditions for people but were predicated on and embedded within racially discriminatory structures and practices. If individuals on the island see the measure as unjustifiable coercion, should that assessment guide quarantine policy in a different direction? If they hold themselves not to be coerced because (although they may not leave), they enjoy their better living conditions (and perhaps would not choose to leave), then is the quarantine policy ethically unproblematic? In a time where public health is increasingly politicised and people are mistrustful of public health authorities and science, the opposite may be a risk, wherein every state action is seen as coercive and unjustifiable to certain groups.

What emerges from this discussion is that we must not allow an overemphasis on subjective experiences to lead to the equation of negative experience with coercion, or with a policy being unjustified. By the same token, a positive subjective experience of an unjustified coercive measure may not serve to independently justify coercion. Such individual and community perspectives are essential in informing us about how lived experience and contexts affect the experience of a coercive measure, and therefore the acceptability of that coercion (Munt and Littlechild 2024). They also feature as important empirical data backing up premises in

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theoretical, principle-based arguments that might ethically justify coercive public health interventions by states (Johnson 2024). But, for the reasons outlined above, these perspectives should not be used as the sole means of *classifying or evaluating* coercion. It is thus necessary for a responsive definition of coercion—particularly for public health—to be built on empirical inquiry as well as normative analysis. A functional conception of coercion for the purposes of evaluating and informing practice should integrate lived experiences and broader context without being wholly subsumed by them.

When considering the permissibility of coercive public health interventions, how can we consider the structural factors that influence and contribute to ill health?

The final issue that we reflect on returns to the recurring themes and questions of our workshop regarding structural inequities and how to account for these inequities in analysis of coercive actions. In considering the specific examples and case studies of coercion, it was apparent that not all the burdens of interventions fall equally on all individuals in a population and that benefits may also be unequal due to the structural and social determinants of health.

If structural influences on health are clearly central to the effectiveness of a public health response (White 2024), strengthening considerations of structures through focused ethical analysis of context as well as actors involved in coercive actions may offer a means to explicitly include these factors within ethical analysis and may eventually improve the equitable distribution of burdens associated with coercive measures. ‘Structures’ here encompasses systemic forces and societal arrangements that constrain individual autonomy, and perpetuate inequities, contributing to ill health and unfreedom. Unlike explicit coercive acts by the state, structural forces operate through entrenched systems, creating contexts in which individuals have limited or no meaningful alternatives. Simultaneously, coercion may be necessary to bring about just outcomes, meaning that coercion may ameliorate existing health inequities in some circumstances, not only exacerbate them. Yet, despite their clear relevance to the practice and application of public health coercion, structural forces and the role of context in ethical argumentation have remained an underexplored dimension of the debate (although, see Johnson et al. 2024b for work in the area). An example where structural factors might affect the coerciveness of an action is the way that antibiotic prescription mandates in healthcare settings have different effects both on healthcare workers required to adhere to them, and on patients, depending on the healthcare setting, the season, changes in population demographics, and

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other factors (Nayiga et al. 2021). Whilst some constraints may not necessarily be coercive, some cases may seem to be. In a healthcare system where the provision of care is mostly related to the provision of medical drugs, prescription limits may have much greater impact than one in a healthcare system with more staff available to provide other forms of care.

Place is another important structural factor. The place where coercion occurs heavily impacts how burdensome it is: for a very different example, being trapped in a mansion by the sea during a lockdown order is much less burdensome and physically restrictive (and therefore, on at least some accounts of coercion, less coercive) than being trapped in a two-bedroom apartment with four other people in the city during a lockdown (Silva 2025). Similarly, financial conditions can greatly affect how a population experiences coercive measures such as hotel quarantine for which individuals must pay, and whether they see them as justified or not (Pahlman et al. 2024).

We wish to articulate a case for strengthening the consideration of structural factors affecting the coerciveness of a public health action within academic debates on coercive public health measures. Such strengthening might occur via explicit recognition of structures alongside relationships between coercer and coercee as playing a role in coercive action, and explicit evaluation of these structures and how they might cause differential impacts of the coercive measure on different groups of coercees. We do not wish to commit ourselves fully to the idea of a separate form of ‘structural coercion’, but we believe that exploring that possibility could be a fruitful area for further scholarship.

First, by considering more explicitly how structural factors can influence the coerciveness of an action, we provide a lens to consider societal inequity in a manner that is directly relevant to public health. Existing inequities and disparities are often amplified through the burdens imposed by public health interventions, perhaps especially coercive ones. As discussed above, Smith (2025) suggests public health ‘complicates’ coercion, particularly for interventions applied at a population scale, which aim to achieve legitimate public health objectives. Yet, as evidenced during the COVID-19 pandemic, the benefits and harms of such interventions were unequally distributed due to preexisting, structural features of societies. Vulnerable and marginalised communities often bear disproportionate harms, such as loss of livelihood. These must be explicitly considered alongside the more obvious actors and broad effects of a coercer acting upon a coercee (population).

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Disparities in health outcomes are not just attributable to pre-existing inequities, but may even be exacerbated by the design and enforcement of interventions. This creates what Benton referred to during the workshop as "unfreedom, unchoice, and unpower," wherein structural forces influencing coercion become the result of the systemic limitation of autonomy and choice for only some groups, due to societal arrangements, such as economic inequality, institutionalized discrimination, and historical injustices. Examples of this could be seen during the COVID-19 response where poor living conditions would make it impossible for poorer individuals living in informal dwellings without access to clean water and sanitation to comply with handwashing and social distancing measures. Yet, they were often subject to sanctions and penalties for their failure to comply (Abdool Karim 2020). Whether such interventions are just or fair thus turns on the structural factors that allow or limit people's ability to comply with a coercive measure. This example lies at the intersection of structural factors with enforcement mechanisms. The sanctions attached to non-compliance, such as fines or incarceration, disproportionately affect those already disadvantaged by structural inequities. This dual burden underscores the ethical relevance of both the design and implementation of coercive public health measures.

Structural factors influencing coercion may be an important yet under-acknowledged component of coercive public health that is central to ethical evaluation. By constraining autonomy and exacerbating inequities in ways that vary across populations depending on their socioeconomic, geographic, cultural and other circumstances, various structures can shape the context within which state coercion operates and thus influence the acceptability and permissibility of state actions. Thus, integrating structural factors into the ethical evaluation of coercive measures could be important to promoting equity and accountability as well as ensuring ethical use of coercion in public health contexts.

Conclusion

The result of our workshop and ensuing reflections, is that coercion remains ethically and conceptually relevant to public health. Yet, there is a need to 'complicate' our current understandings and conceptualisations of coercion that sit within our various disciplinary silos, to develop more interdisciplinary scholarship and engage in debates that are relevant to coercive public health measures that might be implemented against future threats. To do so in a

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manner that addresses the unique and specific challenges that arise in the context of public health, we must develop a clear definition of coercion – one which accounts for individual experiences, and the role of different actors as well as asymmetries in power and resources, and structural factors that influence the operation of such interventions. Moreover, we could expand our discourse and frameworks for the ethical evaluation of public health interventions to consider aspects relevant to ethically evaluating coercive public health measures, such as enforcement and structural factors.

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